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Delivering informed consent: *Montgomery*, patient autonomy and realistic medicine

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Introduction

This paper will examine some aspects and potential implications of the Supreme Court decision in *Montgomery v Lanarkshire Health Board*.¹ In doing so, it will briefly chart the shift in the development of the standard of care for doctors in the context of the duty to disclose information about the risks of treatment, culminating in *Montgomery* in 2015. The case involved a claim against an obstetrician for inadequate disclosure of the risks of a natural birth. There were complications during the delivery and her baby son, who was starved of oxygen, was born with cerebral palsy. The claimant suffered from diabetes and was small in stature, and argued that she would have opted for a caesarean section had she been fully informed of the risks of a natural birth. The Supreme Court found in favour of the claimant and the decision reinforced the central role of patient autonomy, and the requirement for doctors to focus on the needs of the ‘particular patient’ when discussing potential treatment options. There are however some difficulties with this approach (as discussed below) and the courts still hold the trump card as final arbiters. This model undoubtedly challenges the traditional dominance model of the medical profession, associated with the work of medical sociologist Eliot Freidson, by giving the ultimate power to determine appropriate ‘professional’ standards and skills to the court.

In the wake of the decision, some branches of the profession, for example the Royal College of Surgeons (RCS) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI),

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¹ [2015] UKSC 11, [2015] AC 1430.

have expressed concerns about its implications and issued revised guidance on the consent procedures prior to surgery² and anaesthesia³. These are traditionally areas of clinical practice where procedures carry high risks for patients. Whilst the judgment is undoubtedly long-awaited and welcome for patients and patient rights groups, the medical profession has naturally been concerned about its implications for their clinical practice and therapeutic relationships. The decision comes at a time when the NHS is under increasing pressure. The Red Cross has recently described the health care system in the UK as a ‘humanitarian crisis’⁴ and NHS finances have been described by The King’s Fund as ‘almost at breaking point’.⁵ The King’s Fund identified that between 2010 and 2015, health spending has fallen far below the annual growth rate of previous years and will not cover the increasing demand.⁶ The healthcare system in the UK is undoubtedly facing the greatest financial pressure in decades and this undoubtedly has consequences for those working in the system as well as for patient care.⁷

The paper will explore the impact of *Montgomery* on the medical profession in the context of the broader challenges in the health care system, focusing on the potential consequences for medical education and on the job training and delegation, as well as for clinical practice in certain branches of medicine, notably for practitioners working in general practice and high-risk specialisms, such as surgery and anaesthesia. It concludes with some thoughts on what the decision means for medical professionalism and seeks to contribute to current debates about what it means to be a ‘good doctor’ working in the NHS - a service under acute strain - in the twenty first century.

A brief look at the development of the duty to disclose

² RCS, *Consent: Supported Decision-Making – a good practice guide* (2016) located at <https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/>.

³ AAGBI: Consent for anaesthesia 2017 (January 2017) located at https://www.aagbi.org/sites/default/files/AAGBI_Consent_for_anaesthesia_2017_0.pdf

⁴ See ‘NHS faces ‘humanitarian crisis’ as demand rises, British Red Cross warns’, *The Guardian*, 6 January 2017 located at <https://www.theguardian.com/society/2017/jan/06/nhs-faces-humanitarian-crisis-rising-demand-british-red-cross>.

⁵ The King’s Fund, *Six ways in which NHS financial pressures can affect patient care* (31 March 2016), available at <https://www.kingsfund.org.uk/publications/six-ways>.

⁶ *Understanding NHS financial pressures* (March 2017) located at <https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures>.

⁷ Ibid.

Much ink has been spilled over the last half a century charting the development of the duty of care in the context of the doctor-patient relationship. From its early beginnings in the infamous *Bolam v Friern Hospital Management Committee* decision in 1957,⁸ to the more recent articulation in *Montgomery v Lanarkshire*, judges have grappled with the appropriate standard to be set. As Stanton's work over the years has demonstrated in determining the appropriate conditions for liability in negligence, the courts are driven by a number of factors and required to balance competing interests.⁹ In the context of clinical negligence, there is inevitably tension between protecting the legitimate interests of the profession by preserving their autonomy and expertise; whilst at the same time protecting the interests of patients – in particular a patient's dignity, her right to determine what happens to her body and her ability to give informed consent. More generally in the context of negligence claims against public bodies/authorities, courts are also mindful of the resource implications of imposing liability, and may also consider factors such as the risk of defensive practices and wastefulness of finite resources.¹⁰

As Miola¹¹ has outlined, there are three potential models that could be followed for establishing the standard of care in risk disclosure. It could be judged from the perspective of the objective 'reasonable' professional; the 'reasonable' patient or more subjectively focused on the individual patient. In the former, the question of the appropriate level of disclosure is determined by reference to the reasonable doctor – the professional standard or what has commonly been referred to as medical paternalism. Whereas the latter two are patient-centred standards – and what the patient reasonably should or wants to know. The subjective approach would (at least in theory) promote the greatest respect for patient autonomy.

The swing of the pendulum between these approaches is evident in the development of the case law during the last five decades. The *Bolam* test in clinical negligence set the standard of care according to the professional medical standard, which means that a doctor was not negligent if

⁸ (1957) 1 WLR 582.

⁹ See for example KM Stanton, 'Professional negligence: duty of care methodology in the twenty first century' (2006) 22 PN 134; KM Stanton, 'Decision-making in the tort of negligence in the House of Lords' (2007) 15 Tort L Rev 93; KM Stanton 'The neighbour principle in the 21st century: Yesterday's revolution' (2012) 20 Tort L Rev 61.

¹⁰ See for example *Hill v Chief Constable of West Yorkshire* [1989] AC 53; *Smith v Chief Constable of Sussex Police* [2009] 1 AC 225; and *D v East Berkshire Community NHS Trust* [2005] 2 AC 373; and *A v Essex CC* [2004] 1 FLR 749 per Lord Browne-Wilkinson at 749-751 where these factors have prevented the imposition of a duty of care on the police, health care practitioners and social workers.

¹¹ J Miola, 'On the Materiality of Risk: Paper Tigers and Panaceas' (2009) 17 Med L Rev 76.

she acted in accordance with a responsible body of medical opinion. In the words of McNair J:

‘A man need not possess the highest expert skill at the risk of being found negligent .. it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art’ and ‘he is not negligent if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art’.¹²

This was interpreted in subsequent cases to mean that a doctor was not negligent, if she conformed to commonly accepted professional practice. The courts were prepared to accede to the expertise of the medical profession, as the reasonableness of the care fell to be determined by the standards set by the profession. As Lord Scarman stated in *Maynard v West Midlands RHA*,¹³ ‘the law imposes a duty of care: but the standard of care is a matter for medical judgment’. This *Bolam* standard was extended beyond clinical diagnosis and treatment to the extent to which doctors must inform patients of the risks of a proposed treatment. In *Sidaway v Governors of the Bethlem Royal Hospital*,¹⁴ the majority felt that complaints about inadequate risk disclosure should be subjected to the *Bolam* test – so the patient is entitled to know what the doctor thinks she should know.¹⁵ Although even then, there were some differences of opinion among the judges and a strong opposing judgment from Lord Scarman, who was a lone voice in advocating a more prudent-patient approach.¹⁶

This approach to the standard of care was borne out of ‘a long tradition of highly paternalistic medicine’¹⁷ during a period when the medical profession was in the ascendancy. Notions of medical professionalism at that time were very much rooted in autonomy, dominance and self-regulation, in line with the influential work of the medical sociologist, Freidson.¹⁸ According

¹² (1957) 1 WLR 582 at 586.

¹³ [1984] 1 WLR 684 at [639].

¹⁴ [1985] AC 871.

¹⁵ This approach was confirmed by the Court of Appeal in *Blyth v Bloomsbury HA* [1993] 4 Med LR 151 and *Gold v Haringey HA* [1987] 2 All ER 88.

¹⁶ See M Brazier, ‘Patient autonomy and consent to treatment: the role of law’ (1987) 7 LS 169.

¹⁷ R Schwartz and A Grubb, ‘Why Britain Can’t Afford Informed Consent’ (1985) 15(4) *Hastings Center Report* 19, 22.

¹⁸ E Freidson, *Professionalism: The Third Logic* (London: Polity Press, 2001). It is recognised that Freidson provides only one account of professionalisation and the power relationship between doctor and patient. Alternative explanations have also been advanced (see for example the work of M R Haug, *DeProfessionalisation: an alternative hypothesis for the future* in P Halmos, Ed, *The Sociological Review Monograph 20: Professionalisation and Social Change* (1973 University of Keele) 195-211; or

to Freidson, the fundamental criterion that distinguishes a profession from other occupations is its autonomy – which is not absolute but depends on the tolerance and protection of the state.¹⁹ This autonomy and freedom from external control rests on three claims:

- There is such an unusual degree of skill and knowledge involved in professional work that non-professionals are not equipped to evaluate it;
- Professionals are responsible and may be trusted to work without supervision; and
- The profession can be relied on to deal itself with members who behave incompetently or unethically (ie self-regulation).

According to his thesis, professionalism exists:

‘when an organized occupation gains the power to determine who is qualified to perform the defined set of tasks, to prevent all other from performing that work, and to control the criteria by which to evaluate performance’.²⁰

The social context of medicine throughout the 1960s, 70s and 80s was very much orientated towards the profession holding all the cards – as Quick has described, both at the ‘macro’ (profession) and ‘micro’ (individual) level of decision-making.²¹ The *Bolam* standard of regulating medical care conforms to this paradigm, as it enables the medical profession to control performance criteria and standards. This deference to medical opinion demonstrated by McNair J in *Bolam* was very much in tune with societal and political perceptions of doctors and the elevated and privileged status of the medical profession in society, as Schwartz and Grubb highlighted in 1985:

more recently W M Sullivan's work emphasising 'mutual trust': 'Medicine under threat: professionalism and professional identity' (2000) 162(5) *Canadian Medical Association Journal* 673-675. For an account of these various perspectives see M Saks, *Defining a Profession: The Role of Knowledge and Expertise* (2012) 2(1) *Professions and Professionalism* 1-10. The decision in *Montgomery* draws strongly on Freidson's binary model of the doctor/patient relationship as a power dynamic and is the paradigm against which the critique inherent in the judgment is set. Accordingly, this article works from within that framework to analyse the effects of the judgment and its likely impact on medical practice.

¹⁹ E Freidson, *Profession of Medicine, A Study in the Sociology of Applied Knowledge* (Chicago: Chicago University Press, 1970).

²¹ O Quick, *Regulating Patient Safety: The End of Professional Dominance* (Cambridge: CUP, 2017) ch. 1 ('The Rise and Fall of Professional Dominance').

²¹ O Quick, *Regulating Patient Safety: The End of Professional Dominance* (Cambridge: CUP, 2017) ch. 1 ('The Rise and Fall of Professional Dominance').

‘As the proceedings in *Sidaway* indicate, the legal profession defers to its medical counterparts as a part of the tacit agreement to respect the traditional distribution of social power.’²²

This view continued unchallenged for some time. However, with the passage of time, cracks began to appear in the Bolamite philosophy and the professional dominance model was subjected to considerable challenge. The medical profession’s dominance has diminished greatly over the last two to three decades. The cracks appeared during a time of great social and legal flux, and during a period of unprecedented change to the organisation and delivery of health care in the UK. As Quick has outlined,²³ consumerism and managerialism have found their way into the NHS and impacted on the delivery of health care and the work of health care professions. Indeed, Lords Kerr and Reid in *Montgomery* recognised that patients have now become consumers of health care:

[Patients] are also widely treated as consumers exercising choices: a viewpoint which has underpinned some of the developments in the provision of healthcare services’.²⁴

Writing at the turn of the century, Lord Woolf (then Lord Chief Justice) charted this shift from excessive judicial deference of ‘Doctor Knows Best’ in *Bolam* to a more contemporary and critical approach.²⁵ Echoing Grubb and Schwartz, Lord Woolf suggests that the judiciary were reluctant to make findings of negligence ‘against members of any honourable profession’. However, several social and legal changes precipitated the change in judicial attitudes, notably, the highly publicised scandals—the Bristol heart surgery scandal and the crimes committed by GP Harold Shipman—which cast doubt on the beneficence of the profession and dented public trust and confidence. This was accompanied by an increasing awareness of patient rights with the advent of the Human Rights Act 1998; and the growth in the scale of litigation,²⁶ as well as influence from other jurisdictions. This led to a gradual change in approach and judicial

²² Schwartz and Grubb (n 17) p. 22.

²³ Quick (n 21)

²⁴ *Montgomery* (n 1) at [75]

²⁵ Lord Woolf, ‘Are the courts excessively deferential to the medical profession?’ (2001) 9 Med L Rev 1.

²⁶ For example, the NHS Litigation Authority suggests that the number and value of clinical negligence continues to rise each year. The amount of damages paid to patients in the NHS has risen by 23% to 950.4 million in 2015/16 from the previous year (See NHS Litigation Authority, *Annual report and accounts 2015/16 Resolve and learn* (London: HMSO, 2016),

attitudes (as outlined below), culminating in the Supreme Court decision in *Montgomery* which has re-calibrated the doctor-patient relationship and subjects the profession to increasing external scrutiny.

The first signs of the judicial shift appeared in *Bolitho v City and Hackney HA*,²⁷ a case involving potentially negligent treatment in which, for the first time, the court adopted a more critical approach to the *Bolam* test. Lord Browne-Wilkinson sought to limit the reach of *Bolam* and make it clear that it is the court's role to set the standard of care in negligence, not the medical profession. He stated:²⁸

‘[a] doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of the opinion that the defendant's treatment accorded with sound medical practice.’

The court noted that the medical opinion must be reasonable/responsible, which means that it must be ‘capable of withstanding logical analysis’. Lord Woolf believed (and hoped at the time of writing in 2001) that the courts would take this ‘injunction to review the logical basis of expert testimony seriously’.²⁹

In the context of the doctor's duty to disclose, the first indications that they had came in *Penney v East Kent HA*³⁰ and *Marriott v West Midlands HA*,³¹ closely followed by *Pearce v United Bristol Healthcare NHS Trust*,³² where Lord Woolf MR endorsed a prudent-patient standard of disclosure:

‘...if there is a significant risk that would affect the judgment of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt’.³³

²⁷ [1998] AC 232.

²⁸ At 241.

²⁹ Woolf (n 25) p. 10.

³⁰ [2000] Lloyd's Rep Med 41.

³¹ [1999] 1 Lloyd's Rep Med 23.

³² [1998] EWCA Civ 865.

³³ At **.

Both *Wyatt v Curtis*³⁴ and *Chester v Afshar*³⁵ subsequently confirmed this more patient-centred approach.

This shift has impacted significantly on the medical profession and notions of medical professionalism. It has challenged the profession's traditional hegemony and subjected it to increasing external scrutiny. As Lord Woolf opined, this is both necessary and desirable, as:

‘it is unwise to place any profession or other body providing services to the public on a pedestal where their actions cannot be subject to close scrutiny. The greater the power the body has, the more important is this need’.³⁶

These words suggest that, in addition to compensating injured patients for negligently inflicted harm, the court's role is to exercise a ‘restraining influence,’³⁷ and curb the excessive or inappropriate use of power, including professional power in these cases. However, in doing so, it must get the balance right. That means ensuring that sufficient weight is given to the competing interests in determining the scope and standard of the duty of care. Some might ask whether the Supreme Court judges did get that balance right in *Montgomery* and overlooked the interests of the profession.³⁸ This article seeks to contribute to that debate and move beyond the merits of the individual decision, by focusing on some of the broader challenges and potential implications that it could have for the medical profession in the current challenging NHS climate.

³⁴ [2003] EWCA Civ 1779 at [16]: ‘Lord Woolf’s formulation refines Lord Bridge’s test by recognising that what is substantial and what is grave are questions on which the doctor’s and patient’s perception may differ, and in relation to which the doctor must therefore have regard to what may be the patient’s perception’ per Sedley LJ.

³⁵ [2004] UKHL 41 at [16]: ‘In modern law medical paternalism no longer rules and a patient has a prima facie right to be informed by a surgeon of a small, but well established, risk of serious injury as a result of surgery’ per Lord Steyn. Note however that the approach adopted by the House of Lords to the issue of causation in this case has been the subject of some controversy and academic critique (see for example J Stapleton, Occam’s razor reveals an orthodox basis for *Chester v Afshar* (2006) 122 (Jul) *Law Quarterly Review* 426–448).

³⁶ Woolf (n 25) p. 15.

³⁷ Ibid.

³⁸ The judgment is not without its critics, see for example J Montgomery and E Montgomery, *Montgomery on informed consent: an inexperienced decision?* (2016) 42(2) *Journal of Medical Ethics* 89–94.

Montgomery: Risk disclosure and the ‘particular patient’

The decision in *Montgomery* was long-awaited and heralded by some as the final nail in *Sidaway*’s coffin.³⁹ In many respects however, the decision has simply confirmed the direction of travel which was already evident in several earlier decisions of the lower courts.⁴⁰

Briefly, the facts of the case involved Nadine Montgomery who was pregnant, small in stature and suffered from diabetes. Thus, there was a risk (9-10%) that her baby would suffer shoulder dystocia (where the baby’s shoulder gets stuck in delivery) if she gave birth to him naturally. The doctor responsible for her care did not advise her of this risk, nor that the alternative of birth by caesarean section was available, which did not carry the same risk of dystocia (although the procedure did have other risks). Mrs Montgomery elected to give birth naturally and her child was born with cerebral palsy due to complications associated with shoulder dystocia. She stated in her evidence that, had she been informed of the risk of shoulder dystocia, she would have opted for an elective C-section. This evidence was accepted by the defendant in the case.

The Scottish Court of Session had followed the traditional paternalistic approach as applied in *Sidaway*, and found in favour of the defendants. However, on appeal to the Supreme Court, the decision was overturned. The defendants were found to be in breach of their duty of care by not warning of the risks of shoulder dystocia and not being advised of the option of a caesarean section delivery to Mrs Montgomery prior to her labour.⁴¹

³⁹ R Heywood, ‘RIP Sidaway: Patient-Oriented Disclosure – A Standard worth waiting for?’ (2015) 23 Med L Rev 455.

⁴⁰ A-M Farrell and M Brazier, ‘Not so new directions in the law of consent? Examining *Montgomery v Lanarkshire Health Board*’ (2016) 47 *Journal of Medical Ethics* 85; C Foster, The last word on consent? (2 April 2015) *New Law Journal* located at <https://www.newlawjournal.co.uk/content/last-word-consent>. Notably *Pearce v United Bristol Healthcare NHS Trust* and the support for patient autonomy in *Chester v Afshar*.

⁴¹ Note that there were initially two negligence arguments– one relating to negligent treatment (i.e. the decision not to perform the c-section) and the negligence claim in not informing the patient of that option. The Supreme Court only considered the second point.

The Supreme Court reviewed the long line of authorities in *Bolam*, *Sidaway*, *Pearce*, *Chester v Afshar*. They noted that in *Sidaway*, several different approaches had been taken by the Law Lords and concluded that:

‘...the analysis of the law by the majority in *Sidaway* was unsatisfactory in so far as it treated the doctor’s duty to advise her patient of the risks of proposed treatment as falling within the scope of the *Bolam* test.’⁴²

In *Montgomery*, emphasis was placed on the notion of patient autonomy.⁴³ The appropriate legal test was considered and is now established that a doctor is:

‘under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments’.

The test of materiality of a particular risk is:

‘...whether, in the circumstances of the particular case, a **reasonable person in the patient’s position would be likely to attach significance to the risk**, or the doctor is or should reasonably be aware that **the particular patient would be likely to attach significance to it**’ (emphasis added).

Moreover, the court emphasised that:

‘...the assessment of whether a risk is material cannot be reduced to percentages. The significance of a given risk is likely to reflect a variety of factors besides its magnitude: for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patient of the benefits sought to be achieved by

⁴² At [87].

⁴³ It is recognised in the context of the risk disclosure cases that the court’s use of this concept has been contested. As Coggon and Miola have argued, the judicial approach to autonomy has focused on *who* makes the decision and ignored the importance of understanding, thereby confusing autonomy with the concept of liberty – see J Coggon and J Miola, ‘Autonomy, Liberty, and Medical Decision-Making’ [2011] CLJ 523, 523. An examination of how the concept of autonomy is employed by the court in *Montgomery* is beyond the scope of this paper.

the treatment, the alternatives available, and the risks involved in those alternatives. The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient'.⁴⁴

So, the starting point in identifying the doctor's duty should be the needs, concerns and circumstances of the individual patient. The approach is therefore potentially much more subjective and based on the individual characteristics of the particular patient.

The Supreme Court also made it clear that the doctor's role is '*advisory*', and should involve 'dialogue' – to enable the patient to make an informed decision. This means providing information in a comprehensible manner and 'not bombarding the patient with technical information which she cannot reasonably be expected to grasp'.⁴⁵

Finally, the court recognised that there may be exceptions to the doctor's duty to disclose material risks – if they reasonably considered that it would be 'seriously detrimental to the patient's health' ie the so-called therapeutic privilege or exception.⁴⁶ However, the court noted that it should not be abused and would be very limited.⁴⁷ No guidance was provided by the court on the scope of this exception, and this lack of clarity is problematic for the profession as it creates ambiguity and uncertainty. As the RCS' revised guidance on consent has recognised: it 'presents significant legal difficulties for doctors'.⁴⁸ Whilst the appropriate standard of disclosure is now focused primarily on the individual patient, the retention of the reasonable patient standard and the therapeutic exception reminds us that the ultimate arbiter is the court: 'Responsibility for determining the nature and extent of a person's rights rests with the courts, not with the medical profession'.⁴⁹

Patients Rule, OK?

⁴⁴ At [89].

⁴⁵ At [90].

⁴⁶ For further discussion of this exception and other aspects of the judgment see Heywood (n 39); Farrell and Brazier (n 40).

⁴⁷ At [91].

⁴⁸ Royal College of Surgeons (n 6) p 13.

⁴⁹ At [83].

In a paper reviewing the developments of the duty to disclose ‘down under’, Miola found that ‘the ethical imperative on the part of the doctor... is to communicate with the patient rather than just list the risks inherent in the treatment’.⁵⁰ The key focus must be on partnership, dialogue and prioritising communication between the doctor and patient. Miola concluded that the preferred model is New Zealand’s Code of Patients’ Rights, which focuses on the subjective needs of the particular patient and provides a right to effective communication. In line with this, and the ‘supreme status’ that autonomy has attained in health care law and ethics more generally, *Montgomery* has recognised the need to respect the patient’s right to make an autonomous decision. It also mandates the type of subjective approach advocated in New Zealand, and directs the doctor to work in partnership with the individual patient by engaging with and focusing on her wishes, views and values.⁵¹ It moves towards a process of shared decision making,⁵² as doctors must find out what is important to patients in their conversations about proposed treatment options. This approach will help to guide and limit the options for discussion, so they are tailored to the patient’s preferences. The case directs doctors to be guided by the patient and his/her values, not their own – that means taking time to find out about the patient and their lifestyle, hobbies and interests and tailor the information to the patient’s needs.⁵³

For example, the RCS guidance suggests that the risk of loss of sensation in the hand following by-pass surgery may be minor risk to one patient compared to the benefit of increased life expectancy, but it could be a very important risk to another and therefore material, eg a pianist or other skilled workers who rely heavily on their hands to practice their skill, such as carpenters, electricians or plumbers. Similarly, the AAGBI updated advice⁵⁴ includes the example of a professional singer undergoing anaesthesia who would obviously need information about the potential risk of damage to her vocal chords. The focus on patient values

⁵⁰ Miola (n 11) p 105.

⁵¹ Coggon and Miola (n 43); See also J Miola, *Autonomy Rued OK?* (2006) 14 *Med L Rev* 108; S Devaney, *Autonomy Rules OK* (2005) 13 *Med L Rev* 102.

⁵² See M A Durand et al, *Can shared decision-making reduce medical malpractice litigation? A systematic review* (2015) 15 *BMC Health Serv Res* 167 for an interesting review of the available evidence on the impact of shared decision-making on patient’s intentions to initiate litigation. The review concluded that the current evidence is inconclusive and further investigation is required.

⁵³ Royal College of Surgeons (n 6) p 13. In the wake of *Webster (a child) v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62 that includes finding out about any previous treatment decisions as well as the patient’s educational background – both of which were deemed to be material factors by the court.

⁵⁴ S M Yentis et al, ‘AAGBI: Consent for anaesthesia 2017’ (2017) 72 *Anaesthesia* 93.

is key, as it recognises that people can make what others might regard as ‘bad’ choices. It will now be essential for clinicians to carefully document their discussions and the dialogue that takes place with individual patients as part of the process of gaining informed consent.

The judgment is undoubtedly in line with some of the changes that have been taking place more broadly in the health care system during the last decade—specifically the move towards patient-centred care and a more open and honest culture within the NHS. The Francis Inquiry in 2013 into the failures of care in Mid-Staffordshire NHS Foundation Trust had found that hundreds of patients had suffered unnecessarily due to an insidious, negative and highly paternalistic culture. The Inquiry made numerous recommendations aimed at fostering ‘a common culture shared by all in the service of putting the patients first’.⁵⁵ In its wake, the government has been implementing several key reforms to promote a more compassionate and transparent NHS. The changes have included the introduction of the duty of candour ie a legal duty on healthcare providers to inform and apologise to patients if there have been mistakes in their care leading to harm. *Montgomery* has therefore created a much closer symmetry between the legal duties owed to patients both before and after care.

This type of patient specific approach, based on patient preferences, can have several benefits for practitioners and patients, as research by the Kings Fund demonstrates.⁵⁶ The review found that treatment that does not accord with the patient’s wishes can be wasteful, particularly in relation to complex and uncomfortable treatments at the end of life. Also, patients tend to make different choices when they are provided with more information about the potential benefits/risks. For example, the report cites a systematic review that included 11 trials of major elective surgeries. The review found that demand fell by 20% after patients were better informed.⁵⁷ Whilst the longer-term impact on health outcomes of this type of shared decision making are not yet fully known, there is some evidence to suggest that it can improve patient satisfaction with outcomes and their relationship with professionals; improved adherence and

⁵⁵ *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (February 2013) HC 947.

⁵⁶ A Mulley et al, *Patients’ Preferences Matter: Stop the silent misdiagnosis* (The Kings Fund, 2012), available at https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patients-preferences-matter-may-2012.pdf

⁵⁷ *Ibid.* p. 11; See D Stacey et al, Decision aids for people facing health treatment or screening decisions (April 2017) 5 *Cochrane Database of Systematic Reviews* 11.

an enhanced ability for self-management.⁵⁸ These benefits could lead to some efficiency savings in the NHS.

Montgomery accords with this approach as it requires open communication and dialogue between the doctor and patient, thereby encouraging a process of shared decision-making based on patient preferences. It is also in line with GMC professional guidance on consent, which has set the bar at the height of partnership and patient-centred disclosure for some time. As the Supreme Court recognised in *Montgomery*: ‘the guidance issued by the GMC has long required a broadly similar approach.’⁵⁹ The guidance was published in 2008 and provides that:

‘The doctor explains the options to the patient, setting out the potential benefits, risks, burdens, and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice. The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one’.⁶⁰

There is however a caveat to this subjective approach. Whilst the focus is very much on the particular patient and the professional guidance promotes the same approach, *Montgomery* retains references to the reasonable patient and the notion of therapeutic privilege (even though it was not applicable in the case itself). This does not signal a return to *Bolam*, as it refers to the reasonable patient and not the prudent doctor. Patients may have been empowered by the decision, however, where there is any doubt, the judges are still the ultimate arbiters on the appropriate standard. In that sense, the court still holds the trump card and the legal profession retains the balance over the distribution of professional power.⁶¹ This is evident from some of the case law that has flowed from the courts since *Montgomery* in 2015. There had been concerns that *Montgomery* would open the floodgates and lead to a huge increase in claims for

⁵⁸ R Drake et al, ‘Shared decision making in mental health: prospects for personalized medicine’ (2009) 11 *Dialogues Clin Neurosci* 455; See also *Realistic Medicine, Chief Medical Officer’s Annual Report 2014-15* (2015) p 17, available at <http://www.gov.scot/Resource/0049/00492520.pdf>

⁵⁹ At [93].

⁶⁰ *Consent; patients and doctors making decisions together* (June 2008) pp 9-10. Located at http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

⁶¹ For an interesting account of the professional power dynamics between the medical and legal professions, see Petr Skrabanek’s critique of the professional elite in *The Death of Humane Medicine and the rise of Coercive Healthism* (Social Affairs Unit, 1994).

negligent information disclosure, but the case law reveals that has not necessarily been the case. The Court of Appeal in *Webster (A Child) v Burton Hospitals NHS Foundation Trust*⁶² followed *Montgomery* and concluded (on similar facts) that the consultant should have informed the patient of recent (albeit incomplete) research showing the increased risks of delaying labour. However, judges in the lower courts have been more circumspect.⁶³ For example, in *A v East Kent Hospitals University NHS Foundation Trust* the judge rejected a claim that a pregnant woman should have been warned that the small size of her baby might be due to a chromosomal disorder, since any risk of such abnormality was negligible/theoretical. Dingemans J stated:

‘In my judgment the decision in *Montgomery* confirms the importance of patient autonomy, the proper practice set out in the GMC Guidance, and the proper approach set out in *Pearce* and *Wyatt*. It is not authority for the proposition that medical practitioners need warn about risks which are theoretical and not material.’⁶⁴

Furthermore, in other clinical negligence claims, the judges have been equally cautious. For example, the High Court in *Muller v Kings College Hospital*⁶⁵ reinforced the approach in *Bolitho* leading the court to question the medical judgment in the context of a missed diagnosis of a malignant melanoma. And in *Darnley v Croydon Health Services NHS Trust*⁶⁶ the claimant had sustained a head injury following an assault and was taken to hospital. He spoke to the receptionist and left after 19 minutes without being seen by a clinician. His condition deteriorated at home and he returned to hospital by ambulance later that evening, having suffered an extradural haematoma requiring surgery. The claimant alleged that there were

⁶² [2017] EWCA Civ 62.

⁶³ See for example other unsuccessful claims in *Tasmin v Barts Health NHS Trust* [2015] EWHC 3135 (QB) where the court concluded that a risk of 1:1000 is ‘immaterial’ for the purposes of *Montgomery*; *Grimstone v Epsom & St Helier University Hospitals NHS Trust* [2015] EWHC 2756 (QB); *Holdsworth v Luton & Dunstable University Hospital NHS Foundation Trust* [2016] EWHC 3347; *Clark (AP) v Greater Glasgow Health Board* [2016] Scots CSOH 24; and *Surrey v Barnet and Chase Farm Hospitals NHS Trust* [2016] EWHC 1598 (QB) - in a claim involving costs payable by the claimant in clinical negligence litigation to the defendant, the judge said at [95]: ‘I do consider, with respect, that each Costs judge placed too much weight on the suggested analogy with the informed consent issue in the context of medical treatment.’

⁶⁴ [2015] EWHC 1038.

⁶⁵ [2017] EWHC 128 (QB).

⁶⁶ [2017] EWCA Civ 151.

breaches of duty by both clinical and non-clinical staff. However, the Court of Appeal disagreed, finding that the Trust did not have a duty of care to provide accurate waiting times to patients attending Accident and Emergency. Applying *Caparo v Dickman*,⁶⁷ it would not be fair, just and reasonable to impose a duty of care on a receptionist not to give misleading information about waiting times – ‘[t]his would add a new layer of responsibility to clerical staff and a new head of liability for NHS health trusts’ as ‘it is not their function or their duty [of clinical staff] to give any wider advice or information to patients’ (at [53] and [51]). The court was sympathetic to the floodgates argument and concerned about the wider ramifications to the health care system, when 450,000 people per week present to the reception staff in A&E departments across the country. The decision clearly places limits on the expansion of duties that are placed on health care providers. It also implicitly recognises that an autonomy-focused *Montgomery* approach has consequences for patients as well as health care providers and practitioners.⁶⁸ Adults with capacity, such as Mr Darnley, must take responsibility for the consequences of the decisions they make and be prepared to accept any risks that flow from those decisions. In this case, the patient decided to leave the hospital without receiving medical advice after a very short time, which led to a significant deterioration in his physical health necessitating significant medical intervention.

Implications for medical practice and professionalism

Montgomery has generally been well received among the legal community as representing a victory for patients as it reflects a more personalised approach to the delivery of health care and treatment.⁶⁹ However, it may also come at some cost to the medical profession. There has been a marked shift away from the traditional model, but has the pendulum now swung too far the other way? More specifically, what are the consequences of the decision for the workforce in terms of their morale, workloads and practice, medical education and training? And what might that signify for our understanding of modern medical professionalism? These aspects of the decision are explored in the sections below.

⁶⁷ [1990] 2 AC 605.

⁶⁸ See for example commentary on the case at <http://www.pibriefupdate.com/content/pibulj-sec/3368-duty-of-care-hospital-not-liable-for-non-clinical-staff-giving-incorrect-a-e-waiting-time-andrew-cousins-dwf> and <https://nigelpooleqc.blogspot.co.uk>.

⁶⁹ See for example R Bagshaw, ‘Modernising the doctor’s duty to disclose risks of treatment’ (2016) 132 LQR 182-186; M Campbell, ‘*Montgomery v Lanarkshire Health Board*’ (2015) 44 *Common Law World Review* 222; Farrell and Brazier (n 40) 8; Heywood (n 39); C Hobson, ‘No (,) more *Bolam* please: *Montgomery v Lanarkshire Health Board*’ (2016) 79 MLR 468-503.

- **Professional Morale and Workforce Pressures**

Clinicians have already expressed concerns that the judgment may impact negatively on their (already high) workloads and increase the amount of time they must spend with patients, as well as the added bureaucracy and administrative burdens it may create. Moreover, this comes at a time when the NHS is already under severe strain, and there are significant workforce and consequent workload pressures. These are particularly acute in general practice, mental health and also for frontline staff and junior doctors working in Accident & Emergency and other hospital departments.⁷⁰ The revised RCS guidance to surgeons for example recognises that the judgment requires a ‘change in attitude from surgeons’ as they are no longer the sole arbiter of determining what risks are material to their patients.⁷¹ The guidance also cautions that ‘the time and workload pressures facing clinical teams pose significant challenges in providing the right level of support to patients throughout the consent process’.⁷² Clinicians have also been worried about the likelihood of increased litigation in the wake of the decision and what can be done to minimize the risks.⁷³ The RCS guidance directs surgeons to take time to get to know the patient well enough to understand their values, wishes and life priorities. The guidance contains practical advice on how surgeons can optimise the time available with patients, including sending information to the patient in advance to allow him/her sufficient time to read and digest it. A pro-forma /decision aid can be used to guide discussions and will be a helpful tool. Written information can also be provided but it is not in itself sufficient and will not necessarily be tailored to the individual patient. The use of patient decision aids facilitates appropriate conversations and dialogue,⁷⁴ although they do have their limitations and there is a danger that they could come to be regarded purely as a mechanistic tick box approach and thus not sufficiently patient specific. Though of course, the patients must not feel bombarded

⁷⁰ See for example National Health Executive, ‘Critical pressures in NHS workforce put Five Year Forward View in danger (29 April 2015) located at <http://www.nationalhealthexecutive.com/Health-Care-News/five-year-forward-view-in-danger-due-to-critical-pressures-in-nhs-workforce>;

⁷¹ p. 3.

⁷² Ibid.

⁷³ See the GMC blog located at <http://www.bmj.com/content/350/bmj.h1481/rapid-responses> (accessed 27 March 2017) and Royal College of Surgeons, ‘Surgeons warn NHS failing to implement consent rules, risks facing increase in litigation pay-outs’ (27 October 2016) located at <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/surgeons-warn-nhs-failing-to-implement-patient-consent-rules/> (accessed 27 March 2017)

⁷⁴ R Drake et al (n 58).

by too much information and it must be provided in a comprehensible format—which means calibrating it to the individual patient. Consent is viewed as a process of shared decision making—the discussion may take place over more than one session, especially in complex or life changing treatment decisions.

This revised approach will inevitably impact on the amount of time that clinicians are expected to spend with patients discussing the treatment options as well carefully documenting those discussions in the form of maintaining a written decision-making record. The RCS guidance acknowledges that ‘[t]he reality facing surgeons in current practice is that time pressures can leave little opportunity to discuss at length the diagnoses or available treatment options’.⁷⁵ Nevertheless, it recognises that complying with *Montgomery* ‘may well involve setting aside more time for the discussion about consent to treatment’ thereby adding to existing workloads. Surgeons are encouraged to speak to their medical directors about this.⁷⁶

As we know only too well, the medical profession is already feeling the pressure working in the NHS, which is at ‘breaking point’.⁷⁷ This has resulted in a state of unease and dissatisfaction in the health care professions which cannot be ignored. The GMC recently noted in ‘*The state of medical education and practice in the UK 2016*’⁷⁸ that many doctors are feeling the pressure and need to be supported at all levels. The work environment has become increasingly challenging—there has been a period of considerable upheaval in health sector, growing pressures on the NHS and a long dispute over contracts with junior staff in the NHS. A growing number of patients are living with complex needs and the growing ageing population is putting increasing strain on NHS services and staff. The GMC concluded that the level of dissatisfaction among doctors seems to be higher than ever before—indeed, the NHS is ‘under the greatest pressure in generations’.

⁷⁵ RCS (n 6) p. 18.

⁷⁶ Ibid.

⁷⁷ See for example research by The King’s Fund, *Understanding pressures in general practice* (2016) available at www.kingsfund.org.uk/publications/pressures-in-general-practice; The King’s Fund, *How serious are the pressures in social care* (2015), available at www.kingsfund.org.uk/projects/verdict/how-serious-are-pressures-social-care; The King’s Fund, *Mental health under pressure* (2015), available at www.kingsfund.org.uk/publications/mental-health-under-pressure.

⁷⁸ GMC, *The state of medical education and practice in the UK 2016* (2016) pp. ii-iii, available at http://www.gmc-uk.org/SOME2016_Full_Report_Lo_Res.pdf_68139324.pdf.

Levels of satisfaction reported by doctors now suggest that professional morale is of a different order. A BMA survey in 2014 found that just one in five doctors who joined the BMA online research panel was satisfied with their career.⁷⁹ While the 2015 *GP Worklife* survey found that GPs job satisfaction was the lowest and their stress levels highest since the surveys began in 2001.⁸⁰ Nurses are also feeling the strain—a survey by the RCN found that nurses feel unsupported, undervalued and under pressure.⁸¹ The pressure has a negative impact on the environment for education and training—the amount of time dedicated to on the job training is inevitably suffering.⁸² The profession is also angry and frustrated by the challenging working conditions—as witnessed with the recent junior doctor dispute and industrial action over contractual arrangements. And of course, we cannot forget the psychological impact that the threat or fear of litigation may have on health care staff.⁸³ The depth of unease cannot be underestimated and this has a negative impact on professional morale and staff retention, which, in turn, impacts negatively on patient care. Indeed, research in the UK and the US has demonstrated that psychological stress, anxiety and depression among clinicians can impact negatively on patient care. A US study of 123 residents in three paediatric programmes found

⁷⁹ *British Medical Association, Morale decline: work- force survey shows plummeting satisfaction* (2016) available at <http://www.bma.org.uk/news-views-analysis/news/2014/december/morale-decline-workforce-survey-shows-plummeting-satisfaction>.

⁸⁰ J Gibson et al, *Eighth National GP Work- life Survey* (2015), available at <http://www.population-manchester.ac.uk/health/economics/research/Reports/EighthNationalGPWorklifeSurveyreport/EighthNationalGPWorklifeSurveyreport.pdf>.

⁸¹ Royal College of Nursing (2015) ‘Nursing morale has “dropped through the floor” – RCN research’ available at <https://www.rcn.org.uk/nursingcounts/news/nursing-morale-has-dropped-through-the-floor-rcn-research>. See also the annual NHS Staff Survey in 2016 which suggests that, every year since 2012, almost 40% of staff responding to the survey felt unwell due to work related stress in the previous 12 months and less than two thirds of staff reported feeling able to deliver the care they aspire to (located at http://www.nhsstaffsurveys.com/Caches/Files/20170306_ST16_National%20Briefing_v6.0.pdf).

⁸² The GMC national training survey in 2016 revealed that over a third of postgraduate training supervisors were not always able to use the time allocated to them as a medical educator specifically for training. 14% reported that there were not always enough staff in their Trust or health board to make sure patients are treated by someone with an appropriate level of clinical experience. These findings not only reinforce the conclusion that education and training are being affected by service pressures, it also suggests that some doctors in training are being asked to perform beyond their level of training. (General Medical Council, *National training survey* (2016), available at <http://www.gmc-uk.org/education/surveys.asp>).

⁸³ See for example G van Dijk, *Should Physicians be Afraid of Tort Claims? Reviewing the Empirical Evidence* (2015) 6 JETL 282; K Turner et al, *The impact of complications and errors on surgeons* (2016) *RCS Bulletin* 404-407; AW Wu, *Medical error: the second victim* (2000) 320 BMJ 726.

that depressed residents made significantly more medical errors than their non-depressed peers.⁸⁴ The working conditions of healthcare providers and overwork contribute substantively to this problem.⁸⁵ Maben's research in the UK had similar findings in a mixed methods study of nurses' experiences of working with elderly patients in acute hospital care.⁸⁶ The study concluded that focus and investment in staff wellbeing is essential for the consistent delivery of high quality care for older people in acute settings.

As the GMC report concludes – 'To value staff is to value patients' and:

'The link between staff and patient satisfaction is strong and has been long established ... the vital importance of active involvement and shared objectives between institutions and professionals, not just for professional wellbeing but critically for the delivery of safe, compassionate care ... The welcome growth of transparency and the decline in patient deference, together with the changing relationship with other professions, have for many changed the way medicine is practised.'⁸⁷

These changes to the way medicine is practiced are challenging and mean that clinicians must utilize and develop approaches that optimise the time spent with patients to ensure that meaningful dialogue takes place within the time constraints. As the Chief Medical Officer for Scotland has suggested in her Annual Report for 2015/16, it is important to make information available in a variety of formats and platforms, which can be tailored to the needs of particular patients. Doctors should make greater use of electronic communication for example, which may be especially helpful to respond to the needs of the '*i-generation and generations of the future*'. As she points out:

'The availability of electronic communication provides other opportunities to enhance understanding and shared decision-making. Recording consultations and producing presentations on handheld devices are good examples that are being developed by a

⁸⁴ A Fahrenkopf et al, 'Rates of medication errors among depressed and burnt out residents: prospective cohort study' (2008) 336 *BMJ* 488;

⁸⁵ See for example I C McManus et al, 'A levels and intelligence as predictors of medical careers in UK doctors: 20 year prospective study' (2003) 327 *BMJ* 139; R J Kirby et al, 'Development of the Approaches to Work and Workplace Climate Questionnaires for Physicians' (2003) 26 *Evaluation and the Health Professions* 104.

⁸⁶ J Maben et al, "'Poppets and Parcels': the links between staff experience of work and acutely ill older peoples' experience of hospital care' (2012) 7 *International Journal of Older People Nursing* 83.

⁸⁷ GMC (n 78) p. vi.

variety of clinical groups. Both enhance the personalization of care as well as information sharing'.⁸⁸

It is imperative that clinicians are provided with appropriate support structures, including tools and training to facilitate this process. NHS Trusts/employers must allow sufficient time for consent to be gained during consultations and professional bodies have a crucial role to play to assist doctors to streamline the process and ensure that it does not become too cumbersome and time consuming. Otherwise there is a real danger that the profession will feel increasingly pressurised by these additional demands, which, in turn, will further reduce staff morale. And that will inevitably impact negatively on the delivery and quality of patient care, which is not what the judges in *Montgomery* intended.

- **A 'one size fits all' approach**

The disclosure duty requires doctors to provide information about '*reasonable alternative or variant treatments*' including their respective risks. The bar for the knowledge required of doctors about the range of treatment options would therefore seem to be set quite high. Moreover, *Montgomery* makes it clear that this duty is universal in nature. Informed consent operates in the same way for all doctors/patients, irrespective of the branch of medicine or specialism practised. All patients are owed the same standard of individual and patient-centred care.

However, this notion of alternatives may be problematic for certain areas of medical practice, especially for GPs and other practitioners working in primary care medicine. As Whitaker has pointed out, their relationship with patients is different to that of a specialist, such as a surgeon or anaesthetist working in secondary care environments.⁸⁹ It may not lend itself as easily to the *Montgomery* model of risk disclosure as a GP's knowledge of the range of alternatives may not be as thorough or detailed as one would expect of a specialist who performs a small range of (albeit high risk) procedures on a more frequent basis:

⁸⁸ *Realising Realistic Medicine* (February 2017) pp 32-33; located at <http://www.gov.scot/Resource/0051/00514513.pdf>

⁸⁹ P Whitaker, 'How one tragic case changed the laws about medical consent for us all' (2015) *New Statesman* 28 May.

‘Operations represent discrete activities: they have readily measurable rates of success; and potential complications are usually well defined’.⁹⁰

As advised by the RCS,⁹¹ letters from surgical consultants usually outline all this information in detail, and is normally sent well in advance to patients. In contrast, most treatments prescribed by GPs tend to be pharmacological in nature and patients may be prescribed several medications over long periods of time. Psychiatrists in particular face these challenges and need direct access to detailed information which may be too complex or voluminous to remember.⁹² Whilst the British National Formulary (BNF) is regarded as the ‘bible’ for physicians and does list side effects, it is not comprehensive, nor does it contain important information about the success rates of particular drugs.⁹³ There are also concerns that recent changes to the BNF have made it more difficult to navigate and use effectively.⁹⁴ As Whitaker concludes, pharmacological information for patients should be accompanied by comparative details about the full range of alternatives, such as ‘dietary change, regular exercise or psychological intervention’.⁹⁵

Physicians may be concerned that they do not currently have access to the full range of information or tools to enable them to discharge the standard of duty that *Montgomery* would seem to require.⁹⁶ Moreover, whilst GPs may have more time (in theory) to get to know patients, build trust, confidence and dialogue, the realities of modern medicine and patient expectations suggest otherwise. A Kings Fund survey of pressures in general practice found that GPs reported patient unwillingness to self-manage minor or self-limiting illness and widespread expectation among patients of a rapid resolution to problems, as this quote from one of the GPs in the study demonstrates: ‘Many expect all their problems to be solved within a single appointment alongside unrealistic demands regarding referrals/investigations/treatments etc’.⁹⁷

⁹⁰ Ibid.

⁹¹ RCS (n 6) p. 12.

⁹² Drake et al (n 58).

⁹³ Ibid.

⁹⁴ See A Bellerby and DS Needham, Using the British National Formulary effectively (2016) 31 *Nursing Standard* 56.

⁹⁵ Whitaker (n 86).

⁹⁶ Ibid.

⁹⁷ The King’s Fund, *Understanding the pressures in general practice* (May 2016) p. 27.

The use of NICE guidelines and evidence based practice (EBP), which is promoted in the NHS, could facilitate the informed consent process. EBP ‘is an approach to health care wherein health professionals use the best evidence possible ie the most appropriate information available, to make clinical decisions for individual patients’.⁹⁸ Guidelines and knowledge gained through research can be used to inform clinical choices. The recent post-*Montgomery* case of *Webster (A Child) v Burton Hospitals NHS Foundation* has reaffirmed that clinicians are now expected to make themselves aware of and pass on information about ‘emerging and recent research’ to patients, even if that research is ‘incomplete’.⁹⁹ But patients and practitioners need timely and comprehensive access to research findings and databases to achieve this. A systematic review by The Kings Fund¹⁰⁰ highlighted that doctors need this type of help to diagnose patient preferences. They need better information as well as access to it, and patients need to have better information too. Current information systems in the NHS may not necessarily be able to effectively deliver the standard of information that *Montgomery* necessitates.¹⁰¹ Research has found significant variations in perception and implementation of EBP among different professional groups.¹⁰² Furthermore, research into the uptake and usefulness of NICE guidelines suggests that there are some doubts and mixed impact in practice, especially in UK mental health services for example.¹⁰³ There may also be too much information available at times for practitioners to assimilate and it can also be very difficult for busy clinicians to find

⁹⁸ KA McKibbin, *Evidence based practice* (1998) 86 *Bull Med Libr Assoc* 396, 397, available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC226388/pdf/mlab00092-0108.pdf>

⁹⁹ [2017] EWCA Civ 62 at [40].

¹⁰⁰ A Mulley et al (n 56) pp. 31 et seq

¹⁰¹ For example, a study into the implementation of NHS information and technology programme in England suggests that implementation has been hampered and progress has been poor. Staff lacked confidence in new IT systems which hindered their ability to access information in a timely and effective manner. See J Hendy et al, ‘Implementing the NHS information technology programme: qualitative study of progress in acute trusts’ (2007) 334 *BMJ* 1360.

¹⁰² Y Weng et al, Implementation of evidence-based practice across medical, nursing, pharmacological and allied healthcare professionals: a questionnaire survey in nationwide hospital settings (2013) *Implementation Science*, 24 September, available at <https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-8-112>.

¹⁰³ See for example A Court, ‘They’re NICE and neat, but are they useful?: a grounded theory of clinical psychologists’ beliefs about, and use of NICE guidelines’ (D ClinPsych Thesis, Canterbury Christ Church University 2014), available at <http://create.canterbury.ac.uk/12832/>; *Evaluation and Review of NICE Implementation evidence (ERNIE)* located at http://webarchive.nationalarchives.gov.uk/content/20061031160205/http://nice.org.uk/usingguidance/evaluationandreviewofniceimplementationevidenceernie/evaluation_and_review_of_nice_implementation_evidence_ernie.jsp; PD Mankiewicz and C Turner, ‘Do Assertive Outreach clients with experiences of psychosis receive the NICE recommended cognitive-behavioural interventions? An audit’ (2012) 240 *Clinical Psychology Forum* 32.

enough time to keep abreast of all the new research, drugs and range of treatments. As research by The King's Fund has found, 30-40% of care is not based on available evidence, largely due to the difficulties faced by clinicians in keeping abreast with the increasing volume of guidance.¹⁰⁴ Indeed, the current complexity of treatments and outcomes in modern medicine present a fundamental dilemma, as very few medical treatments involve a 'best choice'.

Moreover, shared decision making is not necessarily just about the mechanics of the process. The Supreme Court in *Montgomery* recognised the inherent power imbalance in the doctor/patient relationship, but there are other external dynamics at play, such as the environment or circumstances in which that dialogue takes place. For instance, research into shared decision making has highlighted that the design and layout of the doctor's consulting room can also impact on the dynamics of the relationship and quality of informed consent.¹⁰⁵ Thus, offices should be configured and furnished in a way that puts patients at ease, facilitates communication and enables patients to be active participants in the process.

The challenges are especially acute for primary care practitioners in the current NHS environment. Evidence suggests that patient contact with GPs and primary care services accounts for 90% of all patient interactions with the NHS.¹⁰⁶ But GPs are increasingly feeling the pressure as there has been a marked increase in workload at a time of underinvestment and a shortage of GPs.¹⁰⁷ The GMC's report into the state of medical education pinpointed general practice as a key area for concern. And a recent study in the *British Journal of General Practice* found that lack of time with patients has compromised the ability to practice more patient-centred care, and with it, GPs sense of professional autonomy and values, resulting in diminished job satisfaction.¹⁰⁸ The additional pressures of increased patient demand left many feeling unsupported and vulnerable to burn out and ill-health, and ultimately, to the decision to leave general practice. The study concluded that the pace of administrative change needs to be

¹⁰⁴ A Mulley et al n 56 .

¹⁰⁵ R Drake et al (n 58)

¹⁰⁶ Source <http://content.digital.nhs.uk/primary-care>. See also The patients association, *Primary Care Review* (2012) located at https://www.patients-association.org.uk/our_work/campaigns/primary-care-review/.

¹⁰⁷ See also 'Life of a GP: We are crumbling under the pressures of workload', *The Guardian*, 8 March 2015; 'NHS has the west's most stressed GPs, survey reveals', *The Guardian*, 19 January 2016 (just under 6 in 10 GPs in Britain (59%) find their work stressful. Researchers surveyed 11,547 GPs in 11 countries, including France, Germany and the US).

¹⁰⁸ N Doran, 'Lost to the NHS: a mixed methods study of why GPs leave practice early in England' (2016) *British Journal of General Practice*; 7 January.

minimised and the time spent by GPs on the work that is not face-to-face patient care reduced.¹⁰⁹ Mental health care is another example of a service under increasing strain where demand far outstrips capacity. Workforce capacity in psychiatry has been identified as one of the key challenges in implementing new standards to achieve parity of esteem for mental health care.¹¹⁰ The Commission on Acute Adult Psychiatric Care noted that high case-loads have impacted on staff morale with insufficient time to treat patients with empathy and patience.¹¹¹ And a BMA report into safe working highlighted that staff shortages have led to dangerously high case-loads and physicians are routinely being forced to carry out complex consultations in 10 minutes or under, which can leave patients at risk in many ways.¹¹²

These organisational and economic realities do not feature heavily in the reasoning of the Supreme Court in *Montgomery*. The court's aim was undoubtedly to do justice between the parties and the overriding need was to ensure that the patient's right to information about treatment options was given legal force. The court openly recognised the impact of consumerism for patients and the imbalance in the doctor/patient relationship, but only briefly alluded to the time pressures faced by GPs.¹¹³ It did not explicitly recognise the impact of consumerism on clinicians working in the NHS over the last 20 years and the very real challenges they face in trying to make patient centred care a reality.¹¹⁴ This is unfortunate, as noted above, the correlation between workforce well-being, job satisfaction, and the quality of patient care has been well documented. One would hope therefore that some of these external

¹⁰⁹ See also The King's Fund, *Understanding pressures in general practice* (May 2016).

¹¹⁰ See for example The King's Fund, *Mental health under pressure* (London, 2015).

¹¹¹ *Improving acute inpatient psychiatric care for adults in England* (London, 2015), available at www.caapc.info/

¹¹² BMA, *Safe working in general practice* (BMA, 2016). See also 'Patients at risk from length of GP consultations', BBC News, 29 August 2016, available at <http://www.bbc.co.uk/news/health-37211590>.

¹¹³ See for example '*...an approach which requires the patient to question the doctor disregards the social and psychological realities of the relationship between a patient and her doctor, whether in the time-pressured setting of the GP's surgery, or in the setting of a hospital*' (at [58]) (emphasis supplied).

¹¹⁴ Although the facts of *Montgomery* took place several years ago (in 1999), the rhetoric of health consumerism in terms of patient choice and responsiveness were firmly embedded in the NHS by that time. The NHS Community Care Act in 1990 had introduced the NHS internal market and underfunding and pressures on the service in the 1990s are well documented. See I Greener et al, *How did consumerism get into the NHS? An empirical examination of choice and responsiveness in NHS policy documents* Cultures of Consumption Working Paper Series Working Paper No 29 (Birkbeck College, London: 2006), available at www.consume.bbk.ac.uk/working_papers/GreenerOctober20061.do; BBC News, 'NHS problems 'at their worst' since 1990s' located at <http://www.bbc.co.uk/news/health-32057948>.

constraints would be relevant in the future to determine what amounts to *reasonable* alternatives and variant treatments.

- **Medical Education, Experience and Delegation**

There is a further point which stems from *Montgomery* that could have additional ramifications for future medical education and training. Implicit in the approach taken by the judges to the duty to disclose, is the need for *experienced doctors* to take responsibility for engaging in discussions about risks with patients. For example, the RCS guidance stresses that:

‘.. the discussion about options lies with the surgeon responsible for the patient’s care, or if this is not practical, with an experienced member of the surgical team who has the time and skill to gain sufficient understanding of the patient’s views and wishes. The surgeon discussing treatment with the patient should be suitably trained and qualified to provide the treatment in question and have sufficient knowledge of the associated risks and complications as well as any alternative treatments available for the patient’s condition’.¹¹⁵

The AAGBI guidance similarly refers to the need for consent to be obtained by suitably trained and qualified staff with adequate knowledge of the treatment and full range of risks.¹¹⁶ Some clinicians feel that this approach will hugely prolong the time taken to obtain consent for a given procedure, as it ‘makes it imperative for the doctor performing the procedure to obtain consent him/herself and not to delegate this responsibility to a more junior member of the team which is presently common practice in many units’.¹¹⁷ This causes problems for effective training of junior staff – most of which happens on the job and through direct contact and interactions with patients. As the AAGBI guidance recognises — ‘most learning and maintaining of practical skills occurs during patients’ care’.¹¹⁸ And it undoubtedly places limits

¹¹⁵ RCS (n 6) p. 15; IC Paterson, ‘Consent to Treatment: Somebody Moved the Goalposts’ (1994) 6 *Clin Oncology* 181.

¹¹⁶ SM, Yentis et al, ‘AAGBI: Consent for Anaesthesia 2017’ (2017) 72 *Anaesthesia* 93; 98.

¹¹⁷ See Medical Defence Union, ‘Doctors must ensure patients are aware of material risks’ (16 March 2015), available at www.themdu.com/guidance-and-advice/latest-updates-and-advice.

¹¹⁸ *Ibid.* p. 103.

on the degree to which delegating the informed consent process is now permissible and/or acceptable.

There is also some tension here as, on the one hand, the importance of seeking consent from appropriately qualified and experienced staff is borne out by research conducted with junior doctors and patients. In a study based on questionnaires in the late 1990s, 37 per cent of the junior doctors questioned admitted to obtaining consent for procedures of which they had little understanding; the majority of both junior doctors and patients felt that the surgeon performing surgery should sign the consent form. The study concluded that junior doctors cannot be expected to obtain informed consent for procedures they do not fully understand and patients' expectations must be taken into consideration.¹¹⁹ Another study conducted more recently focused on medical students' perceptions of informed consent and found that most respondents felt ill-equipped and that their training in relation to informed consent had been 'ineffective'.¹²⁰ Much of the undergraduate training around communication has been geared towards reaching an accurate and effective diagnosis in the shortest possible time.¹²¹ The authors of the study concluded that other aspects of the patient-doctor relationship, such as information disclosure, are thereby 'inadvertently de-prioritised'. Most medical training is theoretical and students are not given sufficient practical opportunities to develop their skills to inform patients about treatment options and seek a valid and informed consent.¹²²

So, this reinforces the need for doctors to be given adequate opportunities for this type of practical on-the-job training, especially now that the informed consent process has become more time-consuming and complex. The RCS guidance does recognise that the decision

¹¹⁹ DJ Houghton et al, 'Informed consent: patients' and junior doctors' perceptions of the consent procedures' (1997) 22 *Clin Otolaryngol Allied Sci* 515.

¹²⁰ R Heywood et al, Medical students' perceptions of informed consent: legal reflections on clinical education (2007) 23(3) *Journal of Professional Negligence* 151-164.

¹²¹ W Godolphin, 'The Role of Risk Communication in Shared-Decision Making' (2003) 327 *BMJ* 692.

¹²² R Heywood et al (n 151). See also an empirical study by R Heywood et al, Informed Consent in Hospital Practice: Health Professionals' Perspectives and Legal Reflections (2010) 18(2) *Medical Law Review* 152, which found that health care practitioners remain uncertain about the legal parameters of informed consent and precisely what should be disclosed and when.

requires trainers to give consideration as to how this can be achieved within the newly defined legal parameters.¹²³

These messages from *Montgomery* clearly have implications for the content and delivery of medical education and training. Informed consent is central to the doctor-patient relationship and must therefore be an integral and substantial part of medical training—not just in theory, but also in practice. The GMC has recognised this and redesigned the medical foundation programme curriculum in 2016 to include a component on delivering patient centred care, maintaining trust through effective communication and seeking informed consent.¹²⁴ Moreover, it has been working with the Academy of Medical Royal Colleges to help faculties/colleges embed generic professional capabilities (ie human skills such as communication and team working) into all postgraduate curricula by 2017.¹²⁵

These changes are welcome steps in the right direction and will help the profession to move towards a workforce which embeds these key skills. However, they apply only to those clinicians who qualify in the UK. Recent statistics from the GMC reveal that approximately 40% of doctors on the specialist register and 20% of doctors on the GP register gained their primary medical qualification outside the UK. It is not clear to what extent, if at all, medical education programmes overseas prioritise informed consent and communication skills in the same way as the GMC now does in the UK.¹²⁶ A recent study has found that the prevalence of GMC performance assessments in the UK is significantly higher for those doctors who received their medical qualification outside the UK.¹²⁷ The data from the study highlights that doctors who trained in certain countries within and outside the European Economic Area perform worse than UK graduates. One possible explanation suggested by the authors of the

¹²³ RCS (n 6) p. 16.

¹²⁴ See *Foundation Programme Curriculum* (2016), available at <http://www.foundationprogramme.nhs.uk/pages/home/training-and-assessment>

¹²⁵ See <http://www.gmc-uk.org/education/23581.asp>.

¹²⁶ Note that there is currently some debate about whether all doctors should have their performance assessed by the GMC with reference to the country in which they acquired their medical degree. Moreover, the GMC is keen to use Brexit as an opportunity to give them greater flexibility to assess the competence of foreign doctors, in particular to test the competence of European doctors, which is currently restricted under EU law. See Health Committee, 8th Report, *Brexit and health and social care – people and process* HC 640 (April 2017) para. 72.

¹²⁷ L Mehdizadeh et al, Prevalence of GMC performance assessments in the United Kingdom: a retrospective cohort analysis by country of medical qualification (2017) *BMC Medical Education*, available at <https://bmcmmededuc.biomedcentral.com/articles/10.1186/s12909-017-0903-6>

study is ‘in differences in the way doctors are trained in different countries’.¹²⁸ This undoubtedly presents further challenges for effectively implementing the requirements of *Montgomery* across all sections of the workforce. And of course, these challenges are further compounded in the wake of Brexit. Data from the health and social care information centre suggests that 55,000 of the NHS’s 1.3 million workforce are EU nationals.¹²⁹ The NHS is already struggling to recruit and retain permanent staff and, as the Health Committee has recently identified, there are likely to be further threats to the capacity of the medical workforce until the precise implications of Brexit to EU nationals living in the UK become known.¹³⁰

- **A new approach to medical professionalism?**

So, what does this mean for the future of the medical profession and being a ‘good doctor’ today? Academics have already charted the demise of the dominance model and the erosion of professional autonomy in the medical profession.¹³¹ We have come a long way from Friedson’s model of an autonomous and self-regulating profession. *Montgomery* recognises that we have arrived at a new model of professionalism.¹³² There is a clear signal from the Supreme Court judges that ‘an integral aspect of professionalism in treatment’ is ‘an approach based upon the informed involvement of patients in their treatment, rather than their being passive and potentially reluctant recipients’.¹³³ The focus is now on the central role that patients should play in their care, treatment and recovery. Much of Oliver Quick’s recent work on patient safety argues for a new style of professionalism which allows space for patients to be involved.¹³⁴

¹²⁸ Ibid.

¹²⁹ HSCIC, *NHS Hospital and Community Health Services (HCHS): All staff by nationality and main staff group in England as at 30 September 2015*, available at www.hscic.gov.uk (accessed 27 March 2017)

¹³⁰ See further ‘Five big issues for health and social care after the Brexit vote’, 20 June 2016 located at www.kingsfund.org.uk and the observations in the recent Health Committee 8th Report, *Brexit and health and social care – people and process* HC 640 (April 2017) Section 3. It has been reported that the NHS is already witnessing the loss of EU healthcare staff since the Brexit vote. A record number - 17,197 - EU nationals, including doctors and nurses, left the NHS last year. See ‘NHS to fast-track UK nurses to combat record departures of EU staff’, *The Guardian* 31 March 2017, available at <https://www.theguardian.com/society/2017/mar/31/nhs-fast-track-nurses-record-eu-staff-leave-service-brexit>.

¹³¹ See for example Quick (n 21).

¹³² P Grundy and A Gumbs, ‘Bolam, Sidaway and the Unrecognised Doctrine of "Informed Consent": A Fresh Approach’ [1997] JPIL 211.

¹³³ At [78].

¹³⁴ Ibid.

Similarly, a Royal College of Physicians Working Party report in 2005 advocated a new type of professionalism where the focus is shifted to partnerships and patients.¹³⁵

The focus on the interests of patients is clearly important, but this new model of professionalism must also acknowledge the interests of the profession and the hurdles it now faces working in the challenging NHS environment. A report by the Kings Fund has also called for a redefinition of professionalism, but one that also considers the changing context in which healthcare is delivered and recognises the pressures that doctors are now under on many fronts: from growing public demands and expectations (consumerism); increased managerial control (managerialism); new ways of (multi-agency) working and the changes to and growing pressures placed on doctors' working conditions.¹³⁶

Current models of health care are complex and over-stretched and this does not always work best for patients or the aspirations of the workforce. Significantly, the Scottish Chief Medical Officer's annual report for 2014/15 entitled '*Realistic Medicine*'¹³⁷ has recognised that it may not be possible to achieve a true model of shared decision making within the current conditions in the NHS. The report acknowledges that we need '*a system and values change that rebalances decision-making power*'¹³⁸ and concludes that:

'...implementing shared decision-making in practice is problematic given the constraints of delivering healthcare. This may be particularly difficult in hospital settings where professionals and people may have little previous knowledge of each other. In part it needs to be addressed by pragmatic solutions that can dovetail into existing practice, but it also needs considerable organisational and whole systems change to support what is a fundamental shift in the relationship between people and professionals. At its core, it involves making those short and precious interactions that professionals and people have together, as productive as possible.'¹³⁹

¹³⁵ *Doctors in Society: Medical professionalism in a changing world, Report of a Working Party* (2005), available at https://cdn.shopify.com/s/files/1/0924/4392/files/doctors_in_society_reportweb.pdf?15745311214883953343.

¹³⁶ R Rosen and S Dewar, *On Being a Doctor: Redefining medical professionalism for better patient care* (The Kings Fund, November 2004)

¹³⁷ *Realistic Medicine* (n 58).

¹³⁸ *Ibid.* p. 17

¹³⁹ *Ibid.* p. 17.

Her subsequent annual report on ‘*Realising Realistic Medicine*’ has reinforced the need to create the right conditions to realise this model of patient care.¹⁴⁰ It is not just about changing professional attitudes, approaches and cultures, but it also involves having the right infrastructure, capability and capacity to do so.¹⁴¹ This is the crux of the issue. Broader systemic and cultural changes are key to ensuring that patients truly are at the heart of decision-making about their treatment. A recent government review of progress since the Francis Inquiry has highlighted that the system is slowly moving towards a common, patient-centred and compassionate culture, but there is still much more work to be done.¹⁴² As part of that process, the GMC has begun to engage with what it means to be a good doctor and what professional capabilities are needed in the twenty first century. It held a series of events across the UK to discuss the challenges to professionalism that emerge in daily practice.¹⁴³ The report was published in December 2016 and made several key recommendations. A key theme was the lack of time and support to make a reality of reflective practice and the need to provide a supportive culture, improve medical education and lifelong learning and work in partnership with patients. The profession is in a state of unease, however, the report make a number of recommendations to move forward relating to medical education and lifelong learning, promoting a supportive culture and partnerships with patients.¹⁴⁴ Specifically, in the context of informed consent, the report recognises the need for clinicians to be better supported - medical education/ training should be more focused on meaningful patient involvement and the GMC must enhance the materials available to help doctors make decisions in partnership with patients.

Conclusion

The decision in *Montgomery* did not come as great surprise to many health care lawyers, and whilst it has ‘not created a new direction of travel for doctors’, it has certainly speeded up the

¹⁴⁰ *Realising Realistic Medicine* (n 85) Chapter 4.

¹⁴¹ *Ibid.* p. 36.

¹⁴² Department of Health, *Culture Changes in the NHS: Applying the lessons of the Francis Inquiries Executive Summary*, Cm 9009 (2015) para 5.1, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf

¹⁴³ GMC, *Medical professionalism matters: Report and recommendations* (December 2016), available at <https://www.gooddoctors.org.uk/medical-professionalism-matters-report/key-findings-and-recommendations/> (accessed 27 March 2017) p. viii.

¹⁴⁴ *Ibid.* pp. 4-7

journey.¹⁴⁵ It brings with it some unintended consequences for the medical profession and notions of what it means nowadays to be a ‘good’ doctor. As well as potentially adding to the unpredictability of litigation (a point acknowledged in the judgment itself) it will inevitably add to workload pressures, by requiring modifications to how doctors approach treatment decisions with patients and increasing the amount of time spent engaging with them. Professional guidance can help doctors to optimise the time they spend with patients, but it also recognises the challenges posed by this fact specific legal standard. This article has highlighted that the decision has undeniable consequences for certain areas of specialist medical practice and general practice in particular; the design and delivery of medical education/training and the scope for ‘on the job’ training/delegation. These factors are relevant to questions about the core skills/attributes and values we expect from doctors and what being a good doctor should entail. Addressing these challenges is a matter for the relevant professional bodies and royal colleges.

As noted above, some of the relevant bodies have responded to the judgment and already issued revised guidance encouraging surgeons and anaesthetists to modify their approaches. This could improve the accuracy of preference diagnoses to the benefit of patients and practitioners, though research has demonstrated the need for doctors to be supported by robust information systems to do it properly.¹⁴⁶ Moreover, whilst implementing a model of shared decision making to maximise patient preferences offers a range of potential benefits, there are also significant challenges to overcome, as the quote below demonstrates:

‘Implementing shared decision making in routine health care offers considerable promise in terms of ethics, quality, informed decisions, patient satisfaction, enhanced ability for self-management, improved adherence, and meaningful outcomes. Putting these potentialities into everyday practice will be fraught with difficulties. Now is the time to address these barriersas the information explosion and personalized

¹⁴⁵ Whitaker (n 86).

¹⁴⁶ Mulley et al (n 56) p. 30: ‘...a few systems in the United States, including the Group Health Cooperative of Puget Sound, a health maintenance organisation governed by its patients, made great strides in reducing preference misdiagnoses after legislators set a more demanding legal standard – one that requires documentation to show that patients have a clear understanding of their options and likely outcomes. Implementing a measure of the incidence of preference misdiagnoses would, however, require a new investment in information systems.’

medicine will require new educational structures, communication patterns, and decision-making forms'.¹⁴⁷

Montgomery sends out some key messages to doctors about what the legal system expects from medical professionals in the twenty first century. Good doctors must treat their patients with dignity and respect, take time to talk and get to know their individual needs and preferences, and work in partnership with patients. These expectations have been placed on the medical profession by the court with little thought to the context in which healthcare is delivered in the UK and the increasing pressures placed on doctors working in the NHS. Writing in 1985, Grubb and Schwartz¹⁴⁸ highlighted how the conditions in the NHS would not provide a safe harbour for individualised choice. The economics of the US healthcare system allows for consumer choice, whereas a publicly funded system, such as the NHS, could not tolerate patients with real authority to choose health care:

‘The National Health Service cannot afford the caprices of individual patients who may choose medical care that leads to an improper allocation of the community's health care resources. The collective health of the nation cannot be held hostage by a few who wish more expensive treatment. There cannot be consumer sovereignty, and, thus, there cannot be as much respect for patient autonomy and the doctrine of informed consent, within a financially closed system’.

The NHS may have opened-up to an internal market since that time and there is now far greater scope for competition, consumerism and patient choice. Nevertheless, available resources are still finite and the system still cannot afford it – the current financial pressures facing the NHS suggest that these words still ring true today.

Despite these pressures, Lords Kerr and Reed opined that the approach taken in *Montgomery*:

‘...may not be welcomed by some healthcare providers; but the reasoning of the House of Lords in *Donoghue v Stevenson* [1932] AC 562 was no doubt received in a similar way by the manufacturers of bottled drinks. The approach we have described has long

¹⁴⁷ Drake et al (n 58)

¹⁴⁸ Schwartz and Grubb (n 17).

been operated in other jurisdictions, where *healthcare practice presumably adjusted to its requirements*'.¹⁴⁹ (Emphasis supplied).

It sounds like the time has come for clinicians working in the NHS to adjust to the same requirements, though quite how the system is going to afford to do that remains to be seen. The judgment is firmly rooted in principle and respects for patient rights, though by doing so it lacks a degree of realism and pragmatism. No matter how willing and well intentioned clinicians are to put patients first, some of these optimal 'patient-focused' standards are simply unattainable within the current constraints.

Montgomery has set the bar high in terms of the legal standard required to advise patients about their options and give effect to patient preferences in their choice of treatment. Being a good doctor today is far more challenging than it ever has been. If *Montgomery* is to become a meaningful reality, medical students and clinicians at all levels and in all areas of practice must be supported and provided with the appropriate tools to enable them to strive to achieve this individualised patient-centred approach. Individualised patient care and choice is important, but we must also recognise the economic and other realities of the environment in which that care is now delivered and the accompanying challenges this entails. If the future of health care in the UK and the legal framework surrounding it are about working in partnership, that must mean recognising, respecting and valuing the interests of both partners in that relationship.

¹⁴⁹ At [93].